SEVEN
publicações acadêmicas

ASPECTS IN INTENSIVE CARE ASSOCIATED TO TEMPORALITY AND HUMAN CONNECTIONS

ASPECTOS EM CUIDADOS INTENSIVOS ASSOCIADOS À TEMPORALIDADE E ÀS CONEXÕES HUMANAS

ASPECTOS EN CUIDADOS INTENSIVOS ASOCIADOS A LA TEMPORALIDAD Y LAS CONEXIONES HUMANAS

https://doi.org/10.56238/sevened2025.031-026

Jacques Gabriel Álvares Horta[1], Andrea Cristiane Lopes da Silva[2], Sônia Maria de Figueiredo[3], Sidney Augusto Vieira Filho[4], Diego Luiz Teixeira Boava[5], Fernanda Maria Felício Macedo[6], Paulo Henrique de Mirada Cordeiro[7], Deborah Campos de Oliveira[8]

ABSTRACT

Introduction: The Intensive Care Unit (ICU) represents a threshold of "space versus time" in which the human experience reveals itself in a sensitive, radical, and complex.

Objective: To deepen the understanding of human complexity in the ICU environment, reclaim the existential dimension of care, and promote a more humanized practice.

Methodology: Search terms such as ICU environment, Space-time boundary, Temporality, Phenomenology, Existential encounter, and Human sensitivity were accessed from databases. Aspects such as corporeality, pain, encounter with otherness, and the search for meaning are addressed, offering insights for more sensitive and respectful care practices. Temporality and intensive care, relationships on suffering, hope and edge of life are studied.

Discussion: From a phenomenological perspective, the ICU is portrayed as a paradoxical space where high technology coexists with intense human experience. Temporality transcends the succession of moments, becoming an existential dimension marked by the tension between the urgency of interventions and the subjective experience of illness. The ICU transcends its biomedical dimension, becoming a space for the construction of meaning,

[1] Dr. in Health and Nutrition. Intensive Care Unit. Santa Casa de Misericórdia de Ouro Preto. Minas Gerais, Brazil. E-mail: gabriel2alvares@yahoo.com.br
[2] Master's Degree in Health and Nutrition. Universidade Federal de Ouro Preto. Minas Gerais, Brazil. E-mail: andrea.silva@ufop.edu.br
[3] Dr. in Health and Nutrition. Universidade Federal de Ouro Preto. Minas Gerais, Brazil. E-mail: smfigue@ufop.edu.br
[4] Full Professor. Pharmacy Department. Universidade Federal de Ouro Preto. Minas Gerais, Brazil. E-mail: bibo@ufop.edu.br
[5] Dr. in Business Administration. Universidade Federal de Ouro Preto. Minas Gerais, Brazil. E-mail: boava@ufop.edu.br
[6] Dr. in Business Administration. Universidade Federal de Ouro Preto. Minas Gerais, Brazil. E-mail: fernandaboava@ufop.edu.br
[7] Master's degree in Environmental Engineering. Universidade Federal de Ouro Preto. Minas Gerais, Brazil. E-mail: paulo.miranda@aluno.ufop.edu.br
[8] Master's degree in Biotechnology. Universidade Federal de Ouro Preto. Minas Gerais, Brazil. E-mail: dcobiomed@gmail.com

In the ICU, temporality oscillates between the anguish of waiting and the intensity of decisive moments, profoundly impacting patients and families. Technology presents the challenge of avoiding excessive objectification and dehumanization of care. The balance between technical precision and human sensitivity is crucial to ensure the ICU as a space of integral care, preserving the patient's dignity.

Final considerations: The ICU is a place of human encounter, where vulnerability paves the way for the humanization of care.

Keywords: Intensive Care Unity. Existential Dimension. Spirituality. Vulnerability. Quality in Health Care. Critical Illness.

RESUMO

Introdução: A Unidade de Terapia Intensiva (UTI) representa um limiar de "espaço versus tempo" no qual a experiência humana se revela de forma sensível, radical e complexa.

Objetivo: Aprofundar a compreensão da complexidade humana no ambiente da UTI, resgatar a dimensão existencial do cuidado e promover uma prática mais humanizada.

Metodologia: Termos de busca como ambiente de UTI, fronteira espaço-temporal, temporalidade, fenomenologia, encontro existencial e sensibilidade humana foram acessados em bases de dados. Aspectos como corporeidade, dor, encontro com a alteridade e busca de sentido são abordados, oferecendo subsídios para práticas de cuidado mais sensíveis e respeitosas. Temporalidade e cuidado intensivo, relações sobre sofrimento, esperança e limite da vida são estudados.

Discussão: A partir de uma perspectiva fenomenológica, a UTI é retratada como um espaço paradoxal onde a alta tecnologia coexiste com a intensa experiência humana. A temporalidade transcende a sucessão de momentos, tornando-se uma dimensão existencial marcada pela tensão entre a urgência das intervenções e a experiência subjetiva da doença. A UTI transcende sua dimensão biomédica, tornando-se um espaço de construção de significado. Na UTI, a temporalidade oscila entre a angústia da espera e a intensidade dos momentos decisivos, impactando profundamente pacientes e familiares. A tecnologia apresenta o desafio de evitar a objetificação excessiva e a desumanização do cuidado. O equilíbrio entre precisão técnica e sensibilidade humana é crucial para assegurar a UTI como um espaço de cuidado integral, preservando a dignidade do paciente.

Considerações finais: A UTI é um local de encontro humano, onde a vulnerabilidade abre caminho para a humanização do cuidado.

Palavras-chave: Unidade de Terapia Intensiva. Dimensão Existencial. Espiritualidade. Vulnerabilidade. Qualidade na Assistência à Saúde. Doença Crítica.

RESUMEN

Introducción: La Unidad de Cuidados Intensivos (UCI) representa un umbral de "espacio versus tiempo" donde la experiencia humana se revela de forma sensible, radical y compleja.

Objetivo: Profundizar en la comprensión de la complejidad humana en el entorno de la UCI, recuperar la dimensión existencial del cuidado y promover una práctica más humanizada.

Metodología: Se accedió a términos de búsqueda como entorno de la UCI, límite espacio-temporal, temporalidad, fenomenología, encuentro existencial y sensibilidad humana en bases de datos. Se abordan aspectos como la corporalidad, el dolor, el encuentro con la alteridad y la búsqueda de sentido, ofreciendo perspectivas para prácticas de cuidado más sensibles y respetuosas. Se estudian la temporalidad y los cuidados intensivos, las relaciones en torno al sufrimiento, la esperanza y el límite de la vida.

Discusión: Desde una perspectiva fenomenológica, la UCI se presenta como un espacio paradójico donde la alta tecnología coexiste con una intensa experiencia humana. La temporalidad trasciende la sucesión de momentos, convirtiéndose en una dimensión existencial marcada por la tensión entre la urgencia de las intervenciones y la experiencia subjetiva de la enfermedad. La UCI trasciende su dimensión biomédica, convirtiéndose en un espacio para la construcción de significado. En la UCI, la temporalidad oscila entre la angustia de la espera y la intensidad de los momentos decisivos, impactando profundamente a los pacientes y sus familias. La tecnología presenta el reto de evitar la excesiva cosificación y la deshumanización de la atención. El equilibrio entre la precisión técnica y la sensibilidad humana es crucial para garantizar la UCI como un espacio de atención integral, preservando la dignidad del paciente.

Consideraciones finales: La UCI es un lugar de encuentro humano, donde la vulnerabilidad abre el camino a la humanización de la atención.

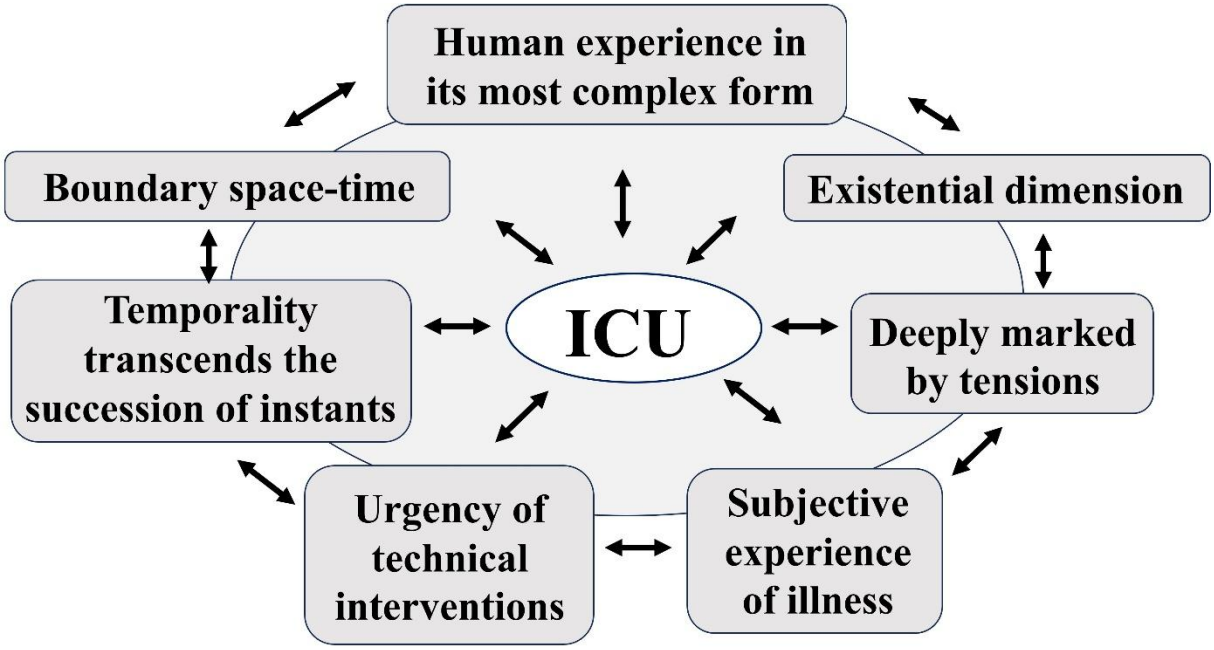
Palabras clave: Unidad de Cuidados Intensivos. Dimensión Existencial. Espiritualidad. Vulnerabilidad. Calidad de la Atención Médica. Enfermedades Críticas.

1 INTRODUCTION

The Intensive Care Unit (ICU) represent a borderline "space-time", in which the human experience reveals itself in its most sensitive, radical and complex form. In this highly complex hospital environment, temporality transcends the mere succession of instants, assuming an existential dimension marked by tension between the urgency of technical interventions and the subjective experience of illness (Martino and Freda, 2016; Gonella et al., 2023; Horta et al., 2025). The main human aspects involved in the ICU environment are showed in Figure 1.

Figure 1

Human aspects involved in the intensive care unit (ICU) environment



Source: Image created by the authors.

In the ICU, life beats between the fragility of the clinical condition and the incessant search for recovery, creating a special place where time expands, contracts and becomes an experience overloaded with meanings. Intensive care, applied on a threshold between life and death, exposes the human condition in its deepest vulnerability (Braithwaite et al., 2017; Perlman, 2021; Horta et al., 2025). In this hospital ward, patients, family members and health professionals share a specific temporality, distinct from conventional chronological time. Time is no longer only measurable in conventional units, but becomes an existential dimension marked by moments of agonizing waiting, crucial decisions and the constant presence of

finitude. Each moment in the ICU involves deep feelings, full of suffering, hope, anguish, religiosity and incessant search for meanings (Gonella et al., 2023; Binder, 2022a, Binder, 2022b; Drillaud et al., 2022; Bäckersten et al., 2023; Beuthin and Bruce, 2024; Horta et al., 2025).

Phenomenology is an approach to understanding the ICU experience. Each moment in the ICU involves a special intensity of feelings, full of suffering, hope, anguish, religiosity and incessant search for meaning. Given the complexity of these feelings, phenomenology emerges as an essential approach to understanding the experience in intensive care (Fabiane and Corrêa, 2007). By focusing on the subjective experience of the people involved, phenomenology allows access to the multiple layers of meaning that permeate the ICU environment. Under the lens of phenomenology, this analysis seeks to explore how temporality, intersubjectivity and medical technology shape the experience of individuals involved in this context.

This study provides a better understanding of human complexity in the ICU environment, seeking to rescue the existential dimension of care and promote a more humanized practice. Aspects of how corporeality, pain, the encounter with otherness and the search for meaning configure the experience in the ICU will be addressed, seeking to offer insights that can guide more sensitive and respectful care practices in the face of the uniqueness of each experience.

2 DATA COLLECTION METHOD

Google scholar, PubMed, Science Direct, Scopus, Web of Science and the Latin American and Caribbean Health Sciences Literature data base (Lilacs) were accessed using search terms such as: ICU environment, Boundary space-time, Temporality, Phenomenology, Existential encounter, Existential dimension and Human sensitivity. Publications in book or scientific article format, written in English or Portuguese were adopted as inclusion criteria. Papers involving laboratory animals and texts published in other languages were excluded.

3 DISCUSSION

The ICU transcends its purely biomedical dimension, configuring as a space for construction of meanings. Although crucial for life support, technology presents a fundamental paradox: the ability to both humanize and de-personalize care. The central challenge lies in finding a delicate balance between technical precision and ethical and

existential sensitivity, ensuring that care in ICU is not reduced to a mechanical act, but manifests itself as a genuine encounter among human beings.

3.1 TEMPORALITY AND INTENSIVE CARE EXPERIENCE

Considering the human aspects in the ICU environment (Figure 1), the time-space experience, permeated by machines, rigid protocols and the constant presence of the fragility of life, challenges traditional conceptions of temporality. Time is not only a continuous and uniform flow, but a transforming territory, capable of reconfiguring the very existence of the human being – be it patient, family or health professional. The experience of time in ICU is profoundly altered, especially for patients with conditions such as intubation. Every moment becomes an internal battle, marked by suffering and vulnerability. This experience is intersubjective: the anguish of a family member, for example, can influence the patient's state and the dynamics of the team, creating a complex field of shared meanings. Therefore, this time field considered as epistemological and multifaceted environment in which the boundaries between objectivity and subjectivity dissolve (Alameddine et al., 2008; Verderber et al., 2021; Mabona et al., 2022; Horta et al., 2025). In this 6retensi, the phenomenology offers us a lens to understand time not as an external and measurable entity, but as a deeply embodied existential dimension (Fabiane and Corrêa, 2007). In practical terms, this means that every second lived in the ICU is not a mere chronological unit but an existential experience, in which meanings are constantly negotiated, and human vulnerability expresses itself in a radical way (Beuthin and Bruce, 2024).

The experience of space-time in ICU also changes throughout the hospitalization. The sense of self and embodiment; experience of time and space; relationship with others; illness experience and overcoming also changes throughout the hospitalization (Magalhães et al., 2017). Critical patients often report a fragmented and disoriented perception of time, influenced by factors such as sedation, pain and cognitive changes. And patients who are recovering tend to rebuild a more linear relationship with time, oriented towards the future, where small clinical advances and significant interactions provide moments of hope and construction of meaning.

Patients recovering in ICU tend to rebuild a more linear relationship with time, oriented towards the future, where small clinical advances and significant interactions offer moments of hope and construction of meaning. For example, a patient who can move a finger after days of immobility experiences a significant time frame, an advance that marks the passage

of time and the possibility of improvement. In this context, Heidegger, (2012) provides a fundamental basis for understanding the temporal experience in the ICU, exploring temporality as constitutive of dasein. For this German philosopher, daisen (being-there) represents everything that is characteristic of the human being, that is, the fact that we are all immersed in temporality.

According to Heidegger, (2012), the experience of time goes beyond a simple chronological measurement; time is not only linear and measurable, but it is intrinsically linked to human existence. This concept acquires relevance in the context of ICU, where chronological time – controlled, measurable and objective (*Kronos*) – coexists with a lived time, fluid and unpredictable (*Kairos*) (Horta et al., 2025).

In ICU, the temporal experience deviates from the conventional notion of time, becoming a life experience that changes the perception of being, whether it is the patient, family member or health professional (Magalhães et al., 2017). *Kronos*, represented by the schedules of medication and medical protocols, presents itself as a controlled and predictable time. In parallel, *7reten* manifests itself in intense existential situations, such as the anguish of waiting for a diagnosis that redefines the patient's own experience.

The body is the very ground in which time is lived (Magalhães et al., 2017; Merleau-Ponty, 2018). Pain, sedation and immobility radically alter the temporal perception, creating a disconnection between lived time and chronological, with moments that expand or compress.

Feelings such as pain, sedation and immobility deeply alter the temporal perception, creating a disconnection between lived time and chronological, with moments that expand or compress. For example, a patient under sedative can lose track of hours or days, while a moment of intense pain may seem to last forever. The dichotomy between *kronos* and *7reten*, presented earlier, serves to illustrate the alternation between the times lived in the ICU, which oscillate between moments of urgency and periods of anguished waiting. Each second in the ICU represents a fine line between life and death, immersing the temporal experience into a state of existential suspension, lived with an unequaled intensity.

In the ICU environment, emotions play a central role in the perception of time (Gonella et al., 2023; Karlsson, Kasén and Wärnå-Furu, 2017; Piras et al., 2022). Anxiety can accelerate temporal sensation, making waiting moments endless, while hope has the power to slow it down, creating a sense of continuity and stability (Piras et al., 2022; Hartog et al., 2013; Brück et al., 2018; Calsavara et al., 2021).

In the ICU environment, emotions play a central role in the perception of time. As an example, waiting for an exam result may seem like an eternity to an anxious family member, while the news of an improvement in the clinical picture can bring relief that slows down the perception of time.

By transforming the world into a “stock”, or “storage” [*Bestand*, (existence) in German], Heidegger (2007) imposes an artificial rhythm to care in the ICU, fragmenting the human experience into protocols and interventions. Technification can lead to excessive concentration on the measurable parameters, neglecting essential human connection. Human interaction, mediated by technological devices, can distance care from subjectivity (Binder, 2022°,b).

Human interaction, essential for the construction of links and meanings in care, is often mediated by technological devices, which can distance care from the subjectivity and emotional needs of the patient. Heidegger, (2007) criticizes this objectification, stating that the technique tends to reduce the human being to a measurable entity, an object to be controlled. For example, communication by monitoring devices, although it transmits vital information, does not replace eye-to-eye contact and attentive listening.

The ICU’s unit work also contributes to the distortion of “space-time” (Alameddine et al., 2008). Its architecture, location of equipments and lighting, creates an environment of confinement and disorientation, which further alters the temporal perception. The patient’s body, in turn, becomes a particular “space-time”, in which the bodily sensations – such as pain, fatigue and the effects of medication – modulate the experience of time in an intense and unpredictable way (Magalhães et al., 2017). Constant light, equipment alarms and the lack of windows can disorient the patient, making it difficult to perceive the passage of time.

Modern medical technology, while preserving life, generates a paradoxical experience of temporal depersonalization. Continuous monitoring devices turn the patient’s body into a “data-collecting object”, where every heartbeat, every breath swing is converted into graphs and numbers. This technological translation of the lived results in a form of silent epistemic violence: the subject is progressively reduced to a set of measurable parameters, losing the singularity of its existence. Reflecting on this process, it is possible to reveal how the technique, when capturing life in its most reducible form, generates an alienation that goes beyond the individual dimension and dehumanizes the experience of being (Horta et al., 2025).

Reflecting on modern medical technology it is possible to reveal how the technique, when capturing life in its most reducible form, generates an alienation that goes beyond the individual dimension and dehumanizes the experience of being. The contemporary philosophy highlights another aspect of technology in ICUs: the computerization of experience. While digitalization of healthcare contributes to the organization and optimization of treatments, it further fragmentary human experience. Patients become datasets, and their individuality is often lost among graphs, numbers, and algorithms. This “depersonalization” is not only a consequence of the technique, but reveals a deeper tendency to dehumanization, where technology becomes the primary mediator of experience, obscuring the subjective and emotional dimensions of care (Horta et al., 2025).

It is essential to reflect on the ethics of care and how to reverse this process, rescuing the human dimension and allowing the temporality of the experience to be genuinely respected. The loss of contact with the patient’s history, their values and preferences to the detriment of computer data analysis exemplifies this dehumanization type.

This analysis is reinforced emphasizing that time in intensive care is not an external sequence of events, but a corporally lived experience (Merleau-Ponty, 2018). The body of the patient, his family and health professionals become a whole in this temporality, where each gesture, breath and look represent a unique temporal density. In the ICU, tubes, monitoring equipment and interventions often transform the body into an existential battlefield and corporeality paradigm acquires an even deeper meaning (Magalhães et al., 2017).

The corporeality paradigm with an even deeper meaning (Magalhães et al., 2017). As example, pain is not just a physical sensation; it modifies the body’s relationship with time and space, dilating or compressing temporal perception, becoming an intense subjective experience (Fabiane and Corrêa, 2007; Costa Gomes and Borges Neto, 2020). However, in the ICU pain is not limited to the individual patient experience. Pain also involves an intersubjective experience, affecting doctors, family members and other professionals. Shared pain alters the time experience of all involved in the care process, creating a collective experience of suffering and waiting (Binder, 2022a; Binder, 2022b; Beuthin and Bruce, 2024). The experience of painful time in the ICU is thus marked by a temporal interdependence, in which suffering dilates time for the patient, while anguish and expectation of family members generate a “waiting time” collective, permeated by a constant transition between hope and hopelessness. This intersubjective dimension of time is crucial to understand the ICU experience. Patients, family members and health professionals share a temporal experience

that transcends individuality and generates a complex network of meanings. The expectation, anguish, hope and fear are not only isolated experiences, but are phenomena of human relationship that constitute themselves in the encounter between subjects. Each look, each gesture of care, each moment of silence carries an unique temporal density, where past, present and future intertwine in a non-linear way. For family members, the time in the ICU is often marked by anguish and uncertainty, which directly influences the patient. The tension between the times lived by the patient and his family generates a collective experience of time, where expectations, fears and hopes intertwine simultaneously (Magalhães et al., 2017).

During the stay in ICU, non-verbal communication assumes a fundamental role in the construction of intersubjectivity (Gonella et al., 2023; Bäckersten et al., 2023; Mabona et al., 2022; Assing Hvidt et al., 2016; Yoo, Lim and Shim, 2020; Hang et al., 2023; Kürtüncü, Kurt and Arslan, 2023; Santana et al., 2024). Gestures, facial expressions and touch become essential elements in patient orientation in time and space, often functioning as an emotional anchor. The presence of families profoundly alters the patient's temporal experience, serving as a reference point that reconnects the patient to elements of daily life and their personal history, providing vital support in this temporally distorted experience (Horta et al., 2025).

The availability of time of health professionals is an essential factor for the humanization of care in the ICU. The concept of the "now" of interaction – "interaction now", "presence now", "immediate interaction" – transcends the punctual moment, becoming a space for intersubjective encounter where meanings are built, hopes negotiated and vulnerabilities shared (Horta et al., 2025).

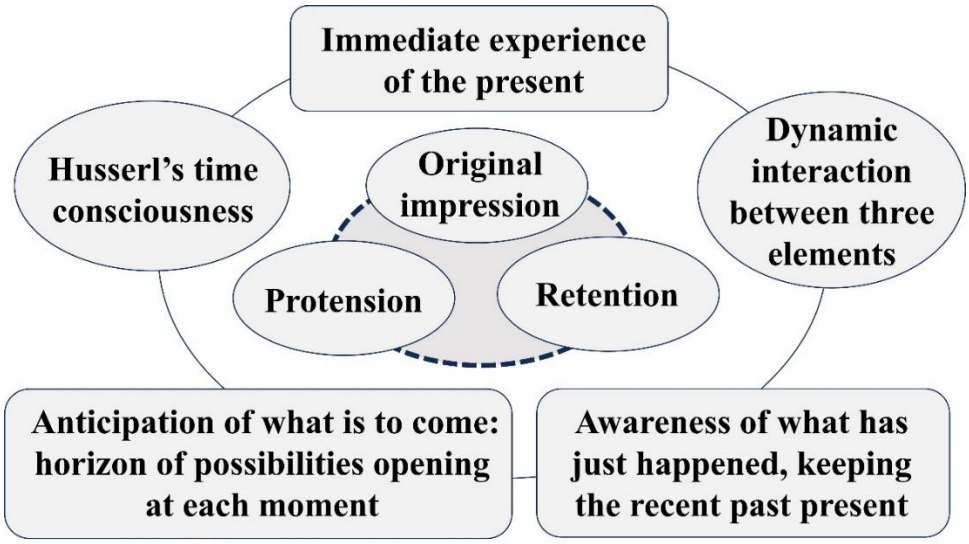
The corporeality of the doctor-patient encounter shapes the experience of time, making it relational and deeply human (Merleau-Ponty, 2018). The interruption of natural sleep and wakefulness cycles in ICU illustrates how the disturbance of body experience alters the experience of time. For the patient, lack of rest can result in a radical discontinuity of time lived, while for family members, the wait is extended into an eternity of uncertainties (Merleau-Ponty, 2018; Binder, 2022b). And, the temporal narratives of patients and their families reveal a multiplicity of experiences (Husserl, 1994).

According to Husserl (1994), the temporal narratives of patients and their families revealing a multiplicity of experiences This German philosopher and mathematician, one of the pioneers of phenomenology, investigated how the narratives of experiences are constituted by the expectations, memories and projections of each subject. For Husserl

(1994), time consciousness is not a succession of isolated instants but a continuous flow formed by the dynamic interaction between three elements: the original impression (the immediate experience of the present), the retention (the awareness of what has just happened, keeping the recent past present) and the 11retension (the anticipation of what is to come, the horizon of possibilities that opens up at every moment) (Figure 2). Expectations are directly related to the 11retension, being the anticipation of the immediate future, such as the evolution of the clinical picture in the ICU, the effectiveness of treatment or the possibility of discharge. The memories, in turn, correspond to retention, bringing to consciousness memories of the past, such as a healthy life before hospitalization or happy moments with the family. The projections cover a broader spectrum, including both 11retension (projections for the immediate future) and long-term plans, goals and desires, such as recovery and return to daily activities (Horta et al., 2025).

Figure 2

Husserl"s time consciousness as a continuous flow formed by the dynamic interaction between original impression, retention and protension



Source: Image created by the authors.

In the ICU, this temporal dynamic manifests itself in different ways (Figure 2). For some people, time is fragmented into moments of intense expectation and anguish. In these cases, the protension becomes loaded with negative emotions, intensifying the awareness of the present as an unbearable waiting. For others, time presents itself as a solution in which the past, present and future are mixed. Consciousness loses the ability to organize time flow in

a linear way, creating a sense of timelessness. The fragmentation of time, often experienced by the patient, contrasts with the anguished expectation of the family members, who experience a time full of protension, focused on the uncertain future of the loved one. This intersubjective experience of time in the ICU, where the experience of one influence the other, connects with the concept of "being-with" [German: *Mitsein*), Heidegger (2012), which addresses how the experience of the other becomes an essential part in the construction of time itself. The term "being-with" refers to an ontological characteristic of the human being, that it is always already with others of its kind. In this sense, corporeality paradigm emerges as a fundamental means of this temporal experience (Magalhães et al., 2017). In ICU, the body is not only a biological object, but an existential territory where human vulnerability manifests itself in an intense way and spiritual traditions or religious aspects offer valuable perspectives for re-signifying the temporal experience in intensive care (Drillaud et al., 2022; Bäckersten et al., 2023; Assing Hvidt et al., 2016; Costa Gomes and Borges Neto, 2020; Horta et al., 2025).

Corporeality paradigm emerging as a fundamental means of this temporal experience (Magalhães et al., 2017). In the ICU, the body is not only a biological object, but an existential territory where human vulnerability manifests itself in an intense way. Pain, sedation and invasive procedures are not only technical interventions, but radically alter the subject's relationship with time and space. A minute of suffering can become an eternity, while hours of unconsciousness dissolve into absolute time-lapse. Spiritual traditions or religious aspects offer valuable perspectives for re-signifying the temporal experience in intensive care (Assing Hvidt et al., 2016; Costa Gomes and Borges Neto, 2020; Drillaud et al., 2022; Bäckersten et al., 2023; Horta et al., 2025). Based on the French philosopher and thinker Ricoeur (1994), it is possible to understand spirituality as an existential narrative that builds meanings beyond the objectivity of technical time, creating a space of transcendence and reconnection with deep values. Spirituality can transform the experience of suffering, generating an alternative to the dominant technical logic in the ICU, enriching the experience of time. In many cultures, time is seen as a cycle, associating illness with continuous spiritual processes, while other cultures adopt a linear view, oriented towards recovery. For those who understand time as cyclical, as in many indigenous and eastern traditions, suffering in the ICU can be seen as part of a natural and spiritual cycle, reinterpreting the experience of pain as a process of transition and transformation. This can modify the perception of time, providing an existential relief in front of the fragility of life. Therefore, spirituality not only generates a new meaning

for pain, but also transforms the way time is lived during intensive care. Spirituality offers a perspective that transcends the purely technical and biomedical dimension, allowing for a more holistic and meaningful understanding of temporal experience (Costa Gomes and Borges Neto, 2020; Drillaud et al., 2022; Bäckersten et al., 2023). And, logotherapy (Frankl, 2024) challenges people to reflect on how borderline experiences, such as those in the ICU.

The Austrian neuropsychiatrist Frankl (2024), founder of logotherapy, that is part of existential and humanistic psychology theories, challenges people to reflect on how borderline experiences, such as those in the ICU, can trigger a profound reassessment of existence. Often, confrontation with finitude and human vulnerability leads to a re-meaning of values and the understanding of life beyond instrumental perspectives. Even in extreme situations, the search for meaning can turn suffering into an opportunity for growth. Pain and suffering in the ICU generate a unique, fragmented temporal experience for patients, where consciousness oscillates between moments of presence and suspension, often resulting in physical alienation.

The institutional organization of the ICU, with its scales of health professionals, protocols and routines, fragments the temporal experience, corroborating the phenomenological view that time is modulated by social and institutional practices.

The institutional organization of the ICU, with its scales of health professionals, protocols and routines, fragments the temporal experience, corroborating the phenomenological view that time is modulated by social and institutional practices. The digitalization of care, although it brings organizational benefits, intensifies depersonalization, reducing the patient to a set of data, and echoes the Heideggerian criticism of technique (Heidegger, 2012). The standardization of patient experience, established through protocols and computerized systems, obstructs the uniqueness of human experience, transforming time into something impersonal and dehumanized. The technology in the ICU not only measures and controls time, but also transforms it. Advances such as the artificial intelligence open good prospects for improving health care and monitoring, but on the other hand they can deepen depersonalization, further distancing the relationship between patient and professional. In this scenario, fundamental and urgent ethical issues arise, such as:

- How to balance technological efficiency with the preservation of subjectivity?
- How to guarantee patient autonomy in an increasingly algorithm-mediated environment?

- How to maintain the humanistic dimension of care in the midst of increasing technification?

The above questions challenge contemporary medical practice and also lead to a profound rethinking of the relationship between technology, care and human experience. The ICU presents itself as a microcosm where these tensions are manifested in a particularly intense and revealing way. Therefore, the phenomenological understanding of temporality in the ICU requires a careful look at the interactions between technique, corporeity and subjectivity, seeking to rescue humanity and the uniqueness of each experience, without losing sight of the ethical and existential challenges that intensive care imposes. Thus, the ICU must become a space where technology and technique, although indispensable, do not erase humanity from care. It is important to ensure that, in addition to medical efficiency, the subjective experience of the patient is respected and valued, allowing temporality in intensive care to rescue its existential and relational dimension (Horta et al., 2025).

3.2 EXISTENTIAL ENCOUNTER: RELATIONSHIPS ON THE EDGE OF LIFE

The experience of intensive care is presented as an existential environment where the human condition is confronted in its most radical vulnerability. The space between life and death “linearity” goes beyond traditional medical protocols, shaping itself as deeply meaningful encounters that challenge our ordinary understanding of care (Piras et al., 2022; Hartog et al., 2013; Yoo, Lim and Shim, 2020; Kürtüncü, Kurt and Arslan, 2023; Fabiane and Corrêa, 2007; Apitzsch et al., 2021).

The notion of "liminarity", a transitional phase between one passage and another, such as, being between life and death, can be associated with the philosophy of Heidegger (2012), who explores the human being as a being-in-the-world, constantly facing its finitude. The reality of mortality, by highlighting our vulnerability, opens a space for authenticity in relationships. In the ICU, the presence of another, at the limit of life, calls for a care that goes beyond the technique, becoming also an existential care. Each gesture, in this context, carries a deep meaning, revealing that the dimension of care is not limited to the physical, but extends to the field of being. In this context, contemporary medical technology emerges as an existential paradox. On the one hand, it allows the preservation of life; on the other, it can depersonalize the human experience, as Heidegger’s (2007) report related to objectification by technique, presented earlier. The ICU, with its technical interventions and equipment, exemplifies this reduction of existential complexity to measurable data and

procedures, a process that the philosopher identifies as a form of alienation. In addition, the body in the ICU, as already mentioned, ceases to be an experiential experience to become an object of intervention. The transition from "body itself" to "objectified body", constantly marked by technological interventions, represents a radical transformation in human experience.

The transition from "body itself" to "objectified body", constantly marked by technological interventions, represents a radical transformation in human experience. Intersubjectivity appears as a resistance to the objectification imposed by technique. Attitudes of care, such as a delicate touch, an understanding look, a silent presence, prove more powerful than all the technology involved. These human gestures restore the relational dimension of care and are not limited to expressions of empathy, but they constitute forms of interaction that re-signify the experience of the ICU. They transform the technical and impersonal environment into a space of genuine human contact, opposing the depersonalization brought by technique. Non-verbal communication can generate better results than words, restoring the existential dimension of care (Horta et al., 2025).

Non-verbal communication generating better results than words, restoring the existential dimension of care. Ricoeur (1994) offers a narrative perspective to understand the decisions about treatment in the ICU as intersubjective processes that intertwine biomedical, emotional and existential aspects. The family, a constituent part of the patient's "being-with", actively participates in these choices, which are not restricted to physical survival, but to the construction of meaning before finitude. The philosopher Lévinas, (2008) complements this perspective, proposing care as a fundamental ethical encounter. In the ICU, the vulnerability of the other elevates him to the condition of otherness, inducing an unconditional responsibility that transcends protocols and demands an ethical and deeply human response. In this area of the hospital, communication goes beyond verbal language; silences and gestures carry meanings. Sensitive listening opens space to understand the experience of the other And, Merleau-Ponty (2018) offers a deeper understanding of non-verbal communication. This author argues that the true understanding of the other is not only by words, but through the body, perception and even silence. In the ICU, communication transcends technical protocols; it is more related to the presence of the caregiver and sensitivity to perceive and welcome the experience of the other in its entirety. In this hospital environment, decisions about the extension or interruption of treatments take on a deeply complex ethical and existential dimension.

Traditional medical language often functions as a device for interpersonal distancing. Technical terms and jargon can create hermeneutical barriers, distancing patients and family members from understanding their own processes. A truly therapeutic communication demands the translation of scientific complexities into existential narratives that make sense to those involved (Sykes and Nichols, 2015; Horta et al., 2025).

The evaluation of traditional medical language can be deepened from the work Ricoeur's, which discusses how language is a fundamental means in sense building (Ricoeur (1994; Ricoeur, 2000). When medicine uses a technical and distant language, it can create a break in communication, causing patients and family members to disconnect from the underlying human experience. Translating this language into a more accessible and meaningful form is essential to promote care that touches the existential dimension of the patient and their families (Ricoeur, 2000; Sykes and Nichols, 2015). In a similar sense, Frankl (2024) shows essential perspectives on the ability to find meaning even in borderline situations. In this context, the anticipated mourning is not only a psychological process, but constitutes an existential re-meaning, in which patients and family members elaborate their narratives in front of the imminent finitude. This author argues that even in the face of extreme experiences, such as imminent death, human beings have the ability to find a meaning for their existence. This perspective applies both to patients facing the proximity of death and to family members, who, in the midst of suffering, also need to find a meaning to live it. For Frankl (2024), suffering is not an emptiness, but an opportunity to find meaning, even in the most difficult and painful circumstances.

Thus, the spiritual dimension emerges not as an external element but as a fundamental part of human experience at the edge of life (Gonella et al., 2023). Regardless of specific religious traditions, spirituality is configured as an opening to dimensions of meaning that transcend the immediately measurable (Assing Hvidt et al., 2016). In the context of ICU, spirituality is not reduced to a religious concept, but reveals itself as a search for transcendental meanings that can offer comfort and direction. Even in non-religious contexts, such as those observed in ICU patients, this openness to the transcendent is manifested in the search for a connection, for "something" that goes beyond scientific explanations. Frankl (2024) reports that spirituality, understood in a broad sense, is an important dimension for dealing with suffering and death, allowing the human being to find meaning even in most extreme situations. (**SI.17**).

From the perspective of Habermas (2012) it is possible to understand care as a communicative process. Transparency, active listening and dialogue become key elements for a truly humanized medical practice. Communication in the ICU environment is not limited to the transmission of technical information, but is configured as a space of a shared construction of meanings. In medical care there is no one-sided relationship between professionals and patients, but a communication process in which all involved - patients, family members and health professionals - collaborate for the collective construction of meanings, including spirituality.

So, medical practice should be understood as a space of continuous dialogue, where genuine listening and mutual understanding are essential for the integral care of the human being (Gonella et al., 2023; Bäckersten et al., 2023; Assing Hvidt et al., 2016; Hang et al., 2023; Kürtüncü, Kurt and Arslan, 2023).

Properly integrated medical technology can enhance the relational dimension of care. Devices that bring families together, facilitate communication and translate clinical states in a comprehensible way can represent a form of technological humanization. When technology is used to improve communication and care, it can be an agent that, instead of dehumanizing, enhances the relationship between patients, families and health professionals, favoring existential connection. This integration of technology in human care rescues an idea defended by Heidegger (2007), who argues that technology, when used appropriately, can become a means that enables the full expression of the human being, rather than just objectifying it.

In the “special” existential encounter, the subjects - patients, family members and health professionals - are called to an authentic presence. More than mere technical interventors, each one becomes a witness of fundamental processes of human existence, where vulnerability is revealed as a power of connection and transformation. As Heidegger (2012) describes, the authentic existence is given in the recognition of human finitude, and it is in this encounter with the vulnerability of the other that true humanity reveals itself. In the ICU, everyone is called to be a witness and participant of a fundamental experience of life and death, where the interdependence between subjects transforms the technical environment into a space of deep existential connection. In accordance to Costa Gomes and Borges Neto, (2020), medicine and nursing are aware of human finitude, but of a finitude that is not identified with nothingness, emptiness, absence, but with an ethics of hope. Inspired by Merleau-Ponty (2018), the phenomenology of pain reveals it as a vital ontological

dimension, transcending the physical symptom to constitute itself as an existential language that expresses vulnerability and the totality of being. In this perspective, pain, besides being a sign of suffering, can be understood as a form of deep expression of the human condition, involving the totality of being. Radical otherness, a concept developed by Lévinas (2008), finds its deepest expression in the ICU's limit experience. The encounter with the other in its absolute vulnerability invites people to adopt an ethics of responsibility that surpasses any possibility of indifference. Each gesture of care becomes, thus, an ethical event that decentralizes us, withdrawing us from our comfort zone and launching us into an unconditional availability for the other. In this context, the vulnerability of the patient is not only a physical condition, but a situation that requires an ethical response, a commitment to care that goes beyond the technique. In turn, the symbolic dimension of care, understood from Ricoeur's concepts, reveals itself as a complex hermeneutic process (Ricoeur, 1991; Ricoeur, 1994). The rituals, gestures and practices in the ICU environment are symbolic narratives that, while aiming to alleviate suffering, offer a space for the interpretation of life and death. Each act of care is a small story that is built within the great narrative of human existence, allowing the patient and his family to find meaning and meaning in the daily actions of intensive care. Hospitality, a philosophical category worked by Derrida (2003), is revealed as a fundamental dimension of care. Welcoming the other in his radical otherness, especially in the hospital environment, means creating an ethical space in which difference is not only tolerated but celebrated.

Thus, the ICU becomes not a place of isolation, but a space of encounter in which shared vulnerability between the patient and his caregivers allows the emergence of deep and transformative human connections. Hospitality is not a simple gesture of welcome, but an invitation to open up to the otherness of the other, recognizing its totality and complexity. The gesture of welcoming carries an ethical responsibility that cannot be reduced to a simple technical or impersonal procedure, but must be understood as a form of authentic encounter with the humanity of the other. In this intensive care process, the family assumes a prominent role as a fundamental existential territory. It is possible to understand that family otherness is not limited to a biological support, but involves a shared ethical responsibility (Lévinas 2008).

In the hospital environment, the family experience multiple functions: it is a witness, caregiver, interpreter and sometimes including the decision-making potential on the patient's fate.

Lévinas (2008) teaches us that the patient, as a radical otherness, calls the family to an unconditional responsibility, an ethical presence that transcends the simple act of caring and becomes a deep encounter with the vulnerability of the other. This meeting is an experience of care that involves all family members, making each one become part of a collective process of care, reflection and decision. Thus, family dynamics reveal themselves as complex systems of communication and affection. Morin (2005) helps us to understand this complexity. This educator and humanist. author of the epistemology of complexity, argues that human systems cannot be analyzed in a linear or simplistic way, because they involve a constant interaction between their parts (Horta et al., 2025).

Family decisions about patient care do not arise from rigid protocols, but from intersubjective negotiations involving history, values, emotional ties and expectations about life and death. These dynamics create a field of communication and affection essential for decision making, in which care becomes a collective practice that integrates different perspectives, feelings and experiences. Each family member, when making decisions about the treatment of a loved one, participates in a continuous process of construction of meanings, where the ethics of responsibility intertwines with affection and shared memory (Horta et al., 2025).

The training of health care providers needs to transcend the traditional biomedical model (Perlman, 2021). Habermas (2012) shown fundamentals perspectives proposing a more dialogic and transparent communication. It is not just a matter of mastering technical procedures, but of developing relational skills that allow for sensitive listening and a multidimensional understanding of human suffering. Therefore, the training of health professionals must integrate technical knowledge with the ability to be present in an empathic way, listening to the experiences of suffering and taking care not only of the body, but of the human being in its entirety.

Death in the ICU is an event that goes beyond biological dimensions (Drillaud et al., 2022; Bäckersten et al., 2023; Beuthin and Bruce, 2024; Hartog et al., 2013; Gaete Ortega; Papathanassoglou, 2022; Horta et al., 2025). Kübler-Ross, (2017) helps us to understand the psychological processes involved in the end of life, revealing complex stages of emotional elaboration, such as denial, anger, bargaining, depression and acceptance. For patients and their families, the process of finitude or dying is an experience that goes beyond biology, requiring a sensitive and humanized approach. Each of these phases presents a challenge

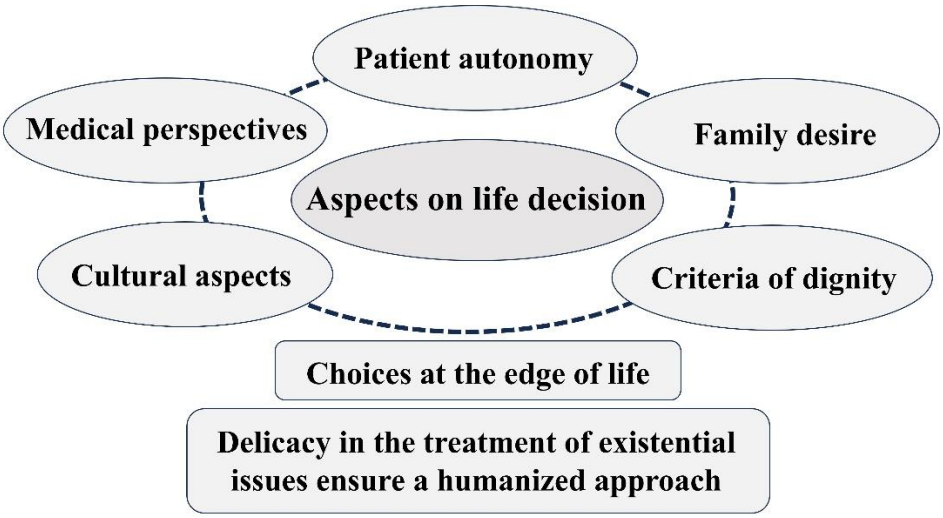
for both health professionals and families and patients themselves, requiring that care goes beyond the technique and embraces the emotional experience of the individual.

In the process of reflection on death, the construction of meaning is neither linear nor predictable. Each person mobilizes internal and external resources to understand and integrate their experiences of suffering. This process involves a complex interaction between emotions, cognitions and spirituality, which must be understood in their entirety. For this reason, care in the ICU needs to be holistic, considering all aspects of the person, not just their biological symptoms. Cultural and religious traditions offer distinct symbolic repertoires to understand finitude. A phenomenological approach inspired by Merleau-Ponty (2018) invites to recognize death not as a point event, but as a continuous existential experience that resignifies the entire vital trajectory. This philosopher suggests that death, like all human experiences, is lived in the body and subjectivity, deeply affecting both the patient and those around him. Thus, death is not only a physical moment, but an existential transformation that must be understood and respected in the care process. The decisions about the end of life are extremely sensitive ethical territories. Ricoeur (2008) established fundamental tools for an ethics of solicitude, in which responsibility arises from the recognition of the vulnerability of the other. This author argues that ethics is not limited to the compliance with rules, but in the commitment to sensitivity to the suffering of others and the responsibility that arises when interacting with them. In the ICU, decisions about life and death require a deep ethical reflection, considering patient autonomy, family wishes, medical perspectives as well as the cultural and spiritual dimensions involved.

In the decisions about life, central elements include patient autonomy, family desire, medical perspectives and cultural and spiritual dimensions, as well as criteria of dignity. Choices made at the edge of life often involve the entanglement of different spheres, and most importantly ensuring that decisions are made in a responsible and respectful manner, with consideration for the needs and perspectives of all involved. In this process, the delicacy in the treatment of existential issues is essential to ensure a truly humanized approach (Figure 3).

Figure 3

Aspects of choices and life decisions made at the edge of life



Source: Image created by the authors.

Regarding to humanized approach, the touch. the caress, emerges as a fundamental language of care. And in the context of ICU, where the physical presence of the patient is often the only possible form of communication, touch becomes essential to maintain connection and ensure that the patient feels recognized and respected (Horta et al., 2025).

In the humanized approach, touch and caress emerge as a fundamental language of care. Merleau-Ponty (2018) contributes to understand touch not only as a mere physical contact, but as an intersubjective experience of recognition. In the ICU environment, where verbal communication is often compromised due to the patient's condition, touch becomes a privileged channel of existential connection. For this philosopher, the body is the basis of the experience of the world, and touch is not only a sensation, but a way to establish a relationship with each other, to recognize their presence and humanity. Nancy, (2000). complements this reflection by exploring touch not only as a sensitive experience but fundamentally as an ethical gesture. For this author, the touch, as an opening of the body to the world and to the other, reveals the vulnerability and the uniqueness of each being. In the ICU environment, where the technification of care can lead to the objectification of the patient, touch assumes a resistance dimension against dehumanization, reaffirming the presence and dignity of the other in a context of extreme fragility. In this sense, touch transcends the mere application of technical protocols, being configured as an act that establishes a deep human connection, promoting solidarity and mutual recognition, indispensable elements for the humanization of intensive care (Nancy, 2000; Beuthin and Bruce, 2024).

3.3 THE MEANING OF SUFFERING AND THE POSSIBILITY OF HOPE

Suffering in the ICU transcends physical pain, becoming a deep existential phenomenon that encompasses multiple dimensions of the human condition (Karlsson, Kasén and Wärnå-Furu, 2017; Binder, 2022a; Binder, 2022.b; Drillaud et al., 2022; Beuthin and Bruce, 2024; Costa Gomes and Borges Neto, 2020). Far from being restricted to a bodily sensation, suffering emerges as an existential question with the potential to transform and reveal new meanings. Frankl, (2024) proposed that suffering should not be seen as a passive condition, but as a potential space for re-meaning and search of meaning, even in the most extreme situations. This perspective resonates with Heidegger, (2012), who, reflecting on finitude, argues that death is not only the end, but an invitation to live in a more authentic way. For Heidegger (2012), suffering and the proximity of death calls people to become more aware of their existence, which enhances their ability to find meaning especially in the most painful moments. However, in an ICU, pain is not a homogeneous phenomenon; it expresses itself specifically in each patient and family, involving emotional, psychic and spirital dimensions.

In an ICU, pain is not a homogeneous phenomenon; it expresses itself specifically in each patient and family, involving emotional, psychic and spiritual dimensions. And, phenomenology, as an analytical tool, enables the understanding of these multiple layers of experience, revealing how suffering is constituted in a deeply subjective process. Moreover, as reported earlier, vulnerability to suffering emerges as an ethical meeting point that leads a person to assume unconditional responsibility for the other (Lévinas, 2008). In this scenario, the humanized approach to care becomes fundamental, since the experience of suffering is not limited to biological parameters, but requires an integral consideration of the human being.

The proximity of death, an inevitable aspect in ICU, is an invitation to the person to reassess their existence (Karlsson, Kasén and Wärnå-Furu, 2017; Drillaud et al., 2022; Bäckersten et al., 2023; Beuthin and Bruce, 2024). For Heidegger (2012), finitude does not necessarily represent destruction, but it can be a space for opening up to authenticity and new awareness of life. The experience of finitude intensifies the perception of time lived, a *Kairos* that makes every second meaningful, highlighting the transience of life and the inevitability of death. Paradoxically, this awareness can generate a new way of understanding and valuing life, broadening the understanding about suffering. In this process, spirituality also plays a fundamental role (Ricoeur, 1991; 1994, 2000 and 2008; Heidegger, 2012).

Ricoeur, (1991) understands spirituality as a narrative that does not depend on religiosity, but is an existential dimension capable of integrating suffering and giving it a deep meaning. This perspective allows patients and family members to reconfigure their experience in the ICU, giving a new meaning to pain, either through a religious vision or through a more personal and intimate experience of transcendence. On the other hand, Marcel (2005) discloses that hope is not simply a passing feeling, but a vital force that remains stable even in the most adverse circumstances. In the ICU, hope manifests itself as an existential energy that drives patients and family members to transcend, for brief moments, the limitations imposed by immediate suffering. This movement of hope is also a reflection of intersubjectivity, as it is often shared between patients, family members and professionals, creating an essential support network for resilience in the face of adversity **(Horta et al., 2025).**

In the practice of ICU, hope is not limited to a verbal speech, but is manifested through simple gestures, such as an understanding look or a word of encouragement. Even when the pain is physical and the situation seems hopeless, hope can arise in moments of connection, such as when a family member holds a patient's hand, offering him a silent but meaningful presence. In addition, aesthetic practices such as music and nature contemplation can play a crucial role in this process of humanization of the hospital environment **(Horta et al., 2025).**

Aesthetic practices such as music and nature contemplation play a crucial role in the process of humanization of the hospital environment (Horta et al., 2025). Bachelard, (2008) shows that such practices offer brief moments of escape and serenity, allowing patients and families to find micro-spaces of emotional and psychological rest, even in the midst of the whirlwind of the ICU. In these moments, art represents a powerful tool of re-meaning, which makes it possible to establish connections with broader dimensions of the human being. In the ICU, aesthetic practices can take many forms. For example, music has been used effectively to reduce the perception of pain and anxiety, creating a more welcoming and less impersonal environment. The contemplation of nature, whether through images or by seeing a garden, also provides an "emotional breath", bringing some serenity to the emotional chaos experienced by patients and their families. Such practices help to create small spaces of psychological rest, fundamental for the maintenance of hope and human dignity. When resignified, suffering can become an opportunity for personal growth and strengthening resilience. Each experience-limit experienced in the ICU is an invitation to transformation, a space in which vulnerability reveals internal forces hitherto unknown. This process of re-

meaning is connected to the search for meaning, because it allows the subject to find a purpose, even in the face of adversity. The construction of personal narratives, which reinterpret suffering experiences, acquires great importance in this process. By sharing these narratives, patients and family strengthen their interpersonal ties and reconstruct their trajectories with a new look. In this framework, death is no longer seen exclusively as a negative event, assuming a constitutive dimension of human experience. Serene acceptance, transcendence or even the denial of death become distinct forms of meaning, which vary according to the individual and his experience of suffering. This reflection on death dialogues with the understanding of finitude reported earlier, showing the need for care that preserves human dignity, especially in view of the end of life (Horta et al., 2025).

Phenomenology shows that suffering is not an external event to the subject, but a deeply rooted experience in the human being. Every gesture, silence and tear in the ICU carries with it an immense potential of meaning that cannot be reduced to simplistic explanations. Non-verbal communication, sensitive listening and the authentic presence of the caregiver are essential elements in this process (Drillaud et al., 2022; Bäckersten et al., 2023; Beuthin and Bruce, 2024; **Horta et al., 2025**).

Each gesture, moment of silence and tear in the ICU carries with it an immense potential of meaning that cannot be reduced to simplistic explanations. Non-verbal communication, sensitive listening and the authentic presence of the caregiver are essential elements in this process. As an example, when a patient is in severe pain and cannot express himself verbally, the simple gesture of a caregiver to give him full attention while maintaining a calm and welcoming look can be more valuable than any word. It is important to highlight that hope is not a way of denying the reality of suffering, but an existential opening that allows the subject to remain connected with the possibility of meaning, even in the most difficult situations. The feeling of hope is a vital force that reinvents itself continuously, allowing the human being to find a meaning, even in the deepest suffering. Hope also connects with the possibility of a future, even if uncertain, and that is what gives life the strength to move forward. The perspective proposed by Merleau-Ponty (2018) broadens the understanding of suffering as an expression of existential corporeality. For this thinker, pain is not restricted to a physical phenomenon, but involves the totality of being, where body, consciousness and context are intertwined. This view reinforces the need for an integral care, which considers pain as an expression of life itself, deserving a care that respects its complexity.

The transience of the human experience in ICU is revealed as an existential territory where fragility and power are interwoven dialectically. Understanding suffering not as a fatality, but as a possibility of re-meaning, implies recognizing the human capacity to transform moments-limit into opportunities for growth and self-reflection. Thus, the ICU is both a space of biomedical intervention and a field where the borders between life, death, pain and hope become permeable and deeply interconnected.

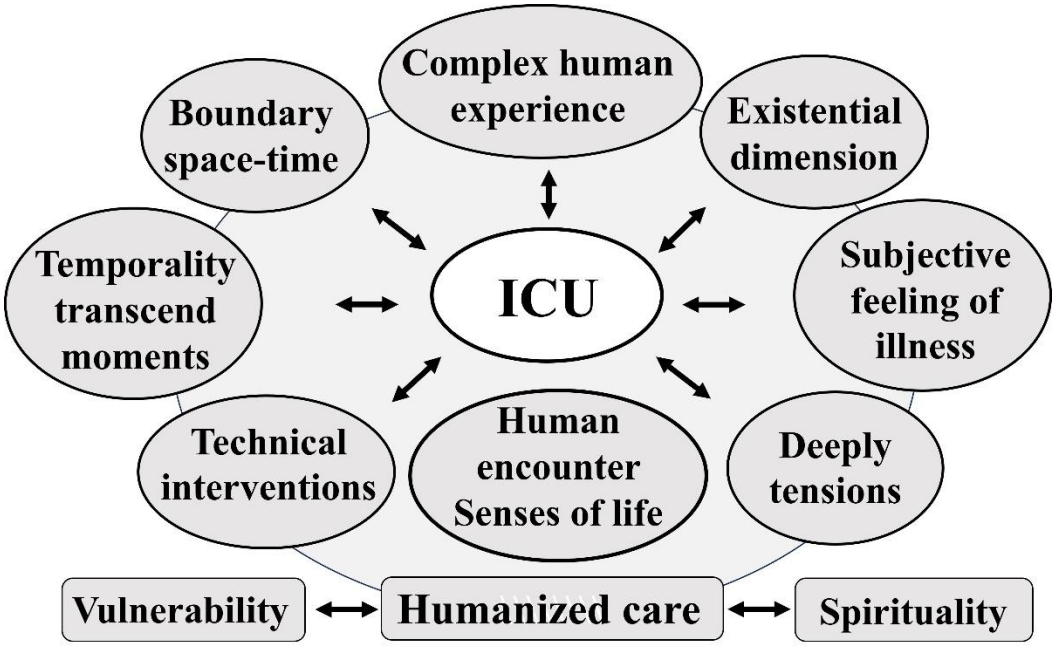
The complexity of suffering in its existential dimension invite health professionals to a practice that transcends technical protocols, approaching an ethics of radical otherness. It is about recognizing that each experience in intensive care carries within itself a special singularity, a unique narrative that cannot be captured entirely by standardized diagnoses or procedures. Then, care is revealed as an act of hospitality where vulnerability is transmuted into ethical power, and hope emerges not as a negation of finitude, but as an affirmation of the human capacity to give meaning even in the limit experiences **(Horta et al., 2025).**

Therefore, it is important that health professionals adopt a holistic approach, recognizing that caring for humans should not be restricted to the biological aspect of suffering. The care must integrate the emotional, psychological and spiritual dimensions of the patient, always seeking to understand suffering in a deep and respectful way. Active listening, authentic presence and consideration of aesthetic practices can be fundamental tools in this care process, contributing to a more humanized experience in the ICU **(Horta et al., 2025).**

Simultaneously, the environment of ICU envolve a complex human experience, existential dimension, bounday space-time, subjective feeling of illness, the temporality transcend moments, deeply tensions, technical interventions that lead to a human encounter with the senses of life, highlighting the importance of humanized care (Figure 4).

Figure 4

Aspects of the environment of an intensive care unit (ICU) that lead to a human encounter with the senses of life, highlighting the importance of humanized care



Source: Image created by the authors.

4 FINAL CONSIDERATIONS

The ICU is a paradoxical space in which high technology coexists with intense human experience. Temporality transcends linearity, oscillating between the anguish of waiting and the intensity of decisive moments, impacting patients and family. Intensive care goes beyond the application of medical techniques, configuring itself as an encounter with the vulnerability of the other. Touch and soft gestures, look, listening and human presence rescue the patient's uniqueness amid the impersonality of technology. Intersubjectivity between patients, family members and professionals weave a network of shared meanings, where pain and hope reflect collectively. Technology, although essential for the preservation of life, represents a challenge: the risk of excessive objectification and consequent dehumanization of care. The balance between technological precision and human sensitivity is important to become ICU as an integral care space, preserving the dignity of the patient at all stages. Suffering transforms and re-signifies. Hope emerges as a vital force that seeks meanings even in adverse situations. ICU is a microcosm where life, death, pain and hope are intertwined, and needs care that transcends the biomedical model, and covers the totality of human experience. Aesthetic practices and the spiritual dimension contribute to humanization,

providing moments of serenity and connection with the transcendent. The reflection on death in the ICU invites to rethink finitude as an integral part of life, requiring an integral and respectful care, with decisions about the end of life taken in a dialogical and sensitive way, considering the autonomy of the patient, family values and medical perspectives.

The ICU, understood as a microcosm where life, death, pain and hope are intertwined, calls for a practice of care that transcends the biomedical model, embracing the totality of human experience. It is noteworthy that the phenomenological analysis of temporality in the ICU directs people to a care that goes beyond technical protocols, seeking a deep understanding of human experience. It is about recognizing the uniqueness of each individual, accepting suffering in its complexity and cultivating hope as a driving force for the re-meaning of life, even in the face of borderline experiences. Thus, the ICU certainly becomes a place of deep human encounter, where vulnerability becomes ethical power and the search for meaning paves the way to the humanization of care.

ACKNOWLEDGEMENTS

The authors are grateful to the Hospital Santa Casa de Misericordia of Ouro Preto Municipality and the Universidade Federal de Ouro Preto, Brazil.

CONFLICT OF INTEREST STATEMENT

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

REFERENCES

Alameddine, M., Dainty, K. N., Deber, R., & Sibbald, W. J. (2009). The intensive care unit work environment: Current challenges and recommendations for the future. Journal of Critical Care, 24(2), 243–248. https://doi.org/10.1016/j.jcrc.2008.03.038

Apitzsch, S., Larsson, L., Larsson, A. K., & Linder, A. (2021). The physical and mental impact of surviving sepsis—A qualitative study of experiences and perceptions among a Swedish sample. Archives of Public Health, 79(1), 66. https://doi.org/10.1186/s13690-021-00585-5

Assing Hvidt, E., Søndergaard, J., Ammentorp, J., Bjerrum, L., Gilså Hansen, D., Olesen, F., Pedersen, S. S., Timm, H., Timmermann, C., & Hvidt, N. C. (2016). The existential dimension in general practice: Identifying understandings and experiences of general

practitioners in Denmark. Scandinavian Journal of Primary Health Care, 34(4), 385–393. https://doi.org/10.1080/02813432.2016.1249064

Bachelard, G. (2008). A poética do espaço. Martins Fontes.

Bäckersten, C., Molander, U., Benkel, I., & Nyblom, S. (2023). “What it is like to be human”: The existential dimension of care as perceived by professionals caring for people approaching death. Palliative & Supportive Care, 20, 1–6. https://doi.org/10.1017/S1478951523001554

Beuthin, R., & Bruce, A. (2024). MAiD as human connection: Stories and metaphors of physician providers’ existential lived experience. Death Studies, 48(9), 916–926. https://doi.org/10.1080/07481187.2023.2293717

Binder, P. E. (2022a). Suffering a healthy life—On the existential dimension of health. Frontiers in Psychology, 13, 803792. https://doi.org/10.3389/fpsyg.2022.803792

Binder, P. E. (2022b). The call of the unlived life: On the psychology of existential guilt. Frontiers in Psychology, 13, 991325. https://doi.org/10.3389/fpsyg.2022.991325

Braithwaite, J., Herkes, J., Ludlow, K., Testa, L., & Lamprell, G. (2017). Association between organizational and workplace cultures, and patient outcomes: Systematic review. BMJ Open, 7(11), e017708. https://doi.org/10.1136/bmjopen-2017-017708

Brück, E., Schandl, A., Bottai, M., & Sackey, P. (2018). The impact of sepsis, delirium, and psychological distress on self-rated cognitive function in ICU survivors—A prospective cohort study. Journal of Intensive Care, 6, 2. https://doi.org/10.1186/s40560-017-0272-6

Calsavara, A. J., Costa, P. A., Nobre, V., & Teixeira, A. L. (2021). Prevalence and risk factors for post-traumatic stress, anxiety, and depression in sepsis survivors after ICU discharge. Brazilian Journal of Psychiatry, 43(3), 269–276. https://doi.org/10.1590/1516-4446-2020-0986

Costa, G. C., & Borges Neto, R. D. S. (2020). Bioética y espiritualidad al final de la vida [Bioethics and spirituality at the end of life]. Cuadernos de Bioética, 31(101), 13–18.

Derrida, J. (2003). Anne Dufourmantelle convida Jacques Derrida a falar da hospitalidade. Escuta.

Drillaud, F., Saussac, C., Keusch, F., Lafaye, D., Bely, H., Averous, V., Frasca, M., Baudry, P., & Burucoa, B. (2022). The existential dimension of palliative care: The mirror effect of death on life. Omega: Journal of Death and Dying, 85(4), 915–935. https://doi.org/10.1177/0030222820952187

Fabiane, U., & Corrêa, A. K. (2007). Relatives’ experience of intensive care: The other side of hospitalization. Revista Latino-Americana de Enfermagem, 15(4), 598–604. https://doi.org/10.1590/S0104-11692007000400012

Frankl, V. E. (2024). Em busca de sentido: Um psicólogo no campo de concentração. Vozes.

Gaete, O. D., Papathanassoglou, E., & Norris, C. M. (2020). The lived experience of delirium in intensive care unit patients: A meta-ethnography. Australian Critical Care, 33(2), 193–202. https://doi.org/10.1016/j.aucc.2019.01.003

Gonella, S., Conti, A., Albanesi, B., Antal, A., Dimonte, V., & Di Giulio, P. (2023). Lived experiences of end-of-life communication among nursing home staff: An interpretive

phenomenological study. Journal of Advanced Nursing, 79(2), 698–710. https://doi.org/10.1111/jan.15489

Habermas, J. (2012). Teoria do agir comunicativo. Martins Fontes.

Hang, A. T., Faria, B. G., Ribeiro, A. C., & Valadares, G. V. (2023). Challenges to patient safety in intensive care: A grounded theory. Acta Paulista de Enfermagem, 36, eAPE03221. https://doi.org/10.37689/acta-ape/2023AO032211

Hartog, C., Schwarzkopf, D., Skupin, H., Kabisch, B., Pfeifer, R., Guenther, A., & Reinhart, K. (2013). Does the ICU experience predict psychological symptoms in relatives of patients with severe sepsis and end-of-life decisions? Critical Care, 17(Suppl 4), P60. https://doi.org/10.1186/cc12959

Heidegger, M. (2007). A questão da técnica. Scientiæ Studia, 5, 375–398.

Heidegger, M. (2012). Ser e tempo. Editora da Unicamp; Vozes.

Horta, J. G. Á., Silva, A. C. L. da, Figueiredo, S. M. de, Vieira Filho, S. A., Boava, D. L. T., Macedo, F. M. F., Cordeiro, P. H. de M., & Oliveira, D. C. (2025). Critical moments: Exploring temporality and human connection in intensive care. Brazilian Journal of Health Review, 8(3), e80614. https://doi.org/10.34119/bjhrv8n3-297

Husserl, E. (1994). Lições para uma fenomenologia da consciência interna do tempo. Imprensa Nacional-Casa da Moeda.

Karlsson, M., Kasén, A., & Wärnå-Furu, C. (2017). Reflecting on one's own death: The existential questions that nurses face during end-of-life care. Palliative & Supportive Care, 15(2), 158–167. https://doi.org/10.1017/S1478951516000468

Kübler-Ross, E. (2017). Sobre a morte e o morrer. Martins Fontes.

Kürtüncü, M., Kurt, A., & Arslan, N. (2023). The experiences of COVID-19 patients in intensive care units: A qualitative study. Omega: Journal of Death and Dying, 87(2), 504–518. https://doi.org/10.1177/00302228211024120

Lévinas, E. (2008). Totalidade e infinito. Edições 70.

Mabona, J. F., van Rooyen, D., & Ten Ham-Baloyi, W. (2022). Best practice recommendations for healthy work environments for nurses: An integrative literature review. Health SA Gesondheid, 27, 1788. https://doi.org/10.4102/hsag.v27i0.1788

Magalhães, D. C., Mitkiewicz, S. F., Marcos, L. G., Susser, E., & Tavares, C. M. (2017). Narrativas corporizadas de superación: ¿Un camino para la recuperación? [Embodied narratives of overcoming: A pathway towards recovery?]. Vertex, 28(136), 450–455.

Marcel, G. (2005). Homo viator. Sígueme.

Martino, M. L., & Freda, M. F. (2016). Meaning-making process related to temporality during breast cancer traumatic experience: The clinical use of narrative to promote a new continuity of life. European Journal of Psychology, 12(4), 622–634. https://doi.org/10.5964/ejop.v12i4.1150

Merleau-Ponty, M. (2018). Fenomenologia da percepção. Martins Fontes.

Morin, E. (2005). O método 1: A natureza da natureza. Sulina.

Nancy, J.-L. (2000). Corpus. Vega Passagens.

Papathanassoglou, E. (2022). A neurobiological framework for the therapeutic potential of music and sound interventions for post-traumatic stress symptoms in critical illness survivors. International Journal of Environmental Research and Public Health, 19(5), 3113. https://doi.org/10.3390/ijerph19053113

Perlman, M. H. (2021). Hands. HCA Healthcare Journal of Medicine, 2(1), 71–72. https://doi.org/10.36518/2689-0216.1212

Piras, I., Piazza, M. F., Piccolo, C., Azara, A., Piana, A., Finco, G., & Galletta, M. (2022). Experiences, emotions, and health consequences among COVID-19 survivors after intensive care unit hospitalization. International Journal of Environmental Research and Public Health, 19(10), 6263. https://doi.org/10.3390/ijerph19106263

Ricoeur, P. (1991). O si mesmo como um outro. Papirus.

Ricoeur, P. (1994). Tempo e narrativa. Papirus.

Ricoeur, P. (2000). A metáfora viva. Loyola.

Ricoeur, P. (2008). O justo. Martins Fontes.

Santana, M. A. P. S., Fonseca, E. R., Roque, K. E., Figueiredo, T. O., Souza, V. M. D., Stipp, M. A. C., & Trotte, L. A. C. (2024). Relational and functional aspects of safety for patients and caregivers in intensive care: Scoping review. Revista Gaúcha de Enfermagem, 45, e20230212. https://doi.org/10.1590/1983-1447.2024.20230212.en

Sykes, D. B., & Nichols, D. N. (2015). There is no denying it, our medical language needs an update. Journal of Graduate Medical Education, 7(1), 137–138. https://doi.org/10.4300/JGME-D-14-00332.1

Verderber, S., Gray, S., Suresh-Kumar, S., Kercz, D., & Parshuram, C. (2021). Intensive care unit built environments: A comprehensive literature review (2005–2020). HERD: Health Environments Research & Design Journal, 14(4), 368–415. https://doi.org/10.1177/19375867211009273

Yoo, H. J., Lim, O. B., & Shim, J. L. (2020). Critical care nurses' communication experiences with patients and families in an intensive care unit: A qualitative study. PLoS ONE, 15(7), e0235694. https://doi.org/10.1371/journal.pone.0235694